		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034991

Facility Name: PARK HOUSE

Address: 2320 S LAWNDALE (Number) CHICAGO (City) 60623 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3620976

Date of Initial License for Current Owners: 01/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	33,544	6		33,550	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,544	6		33,550	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.71%

D. How many bed-hold days during this year were paid by Public Aid?
404 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	136,476	16,788	7,241	160,505		160,505	(444)	160,061			1
2	Food Purchase		122,686		122,686	(12,045)	110,641	(381)	110,260			2
3	Housekeeping	132,472	17,894	0	150,366		150,366	0	150,366			3
4	Laundry	28,820	43,373	0	72,193		72,193	0	72,193			4
5	Heat and Other Utilities			75,151	75,151		75,151	374	75,525			5
6	Maintenance	17,561	32,370	24,003	73,934		73,934	8,564	82,498			6
7	Other (specify):*			14,592	14,592		14,592	0	14,592			7
8	**TOTAL General Services**	315,329	233,111	120,987	669,427	(12,045)	657,382	8,113	665,495			8
	B. Health Care and Programs											
9	Medical Director	0		0	0		0	0	0			9
10	Nursing and Medical Records	838,384	62,769	2,615	903,768		903,768	16,628	920,396			10
10a	Therapy	74,357	2,733	10,800	87,890		87,890	(1,333)	86,557			10a
11	Activities	60,740	8,681	2,376	71,797		71,797	0	71,797			11
12	Social Services	90,082		3,150	93,232		93,232	0	93,232			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			975	975		975	0	975			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,063,563	74,183	19,916	1,157,662	0	1,157,662	15,295	1,172,957			16
	C. General Administration											
17	Administrative	105,358		261,600	366,958		366,958	(185,449)	181,509			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			197,194	197,194		197,194	(164,375)	32,819			19
20	Dues, Fees, Subscriptions & Promotions			23,217	23,217		23,217	(8,086)	15,131			20
21	Clerical & General Office Expenses	17,599	7,070	103,740	128,409		128,409	(24,091)	104,318			21
22	Employee Benefits & Payroll Taxes			259,116	259,116	12,045	271,161	0	271,161			22
23	Inservice Training & Education			675	675		675	323	998			23
24	Travel and Seminar			0	0		0	341	341			24
25	Other Admin. Staff Transportation			249	249		249	1,555	1,804			25
26	Insurance-Prop.Liab.Malpractice			27,519	27,519		27,519	3,018	30,537			26
27	Other (specify):*			0	0		0	25,681	25,681			27
28	**TOTAL General Administration**	122,957	7,070	873,310	1,003,337	12,045	1,015,382	(351,083)	664,299			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,501,849	314,364	1,014,213	2,830,426	0	2,830,426	(327,675)	2,502,751			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PARK HOUSE #0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			32,457	32,457		32,457	41,513	73,970			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest				0		0	287,361	287,361			32
33	Real Estate Taxes			79,785	79,785		79,785	0	79,785			33
34	Rent-Facility & Grounds			365,009	365,009		365,009	(360,625)	4,384			34
35	Rent-Equipment & Vehicles			20,856	20,856		20,856	(5,445)	15,411			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			498,107	498,107	0	498,107	(37,196)	460,911			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			58,035	58,035		58,035	0	58,035			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	58,035	58,035	0	58,035	0	58,035			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,501,849	314,364	1,570,355	3,386,568	0	3,386,568	(364,871)	3,021,697			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,891)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(381)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(11,420)	21		18
19	Entertainment	0	20		19
20	Contributions	(2,197)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(7,306)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,537)	20		28
29	Other-Attach Schedule SEE PAGE 5A	1,289			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,443)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(334,428)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (334,428)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (364,871)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PARK HOUSE

ID# 0034991

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1289	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	1,289		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(6,000)	5,556	0	0	0	0	0	0	0	0	(444)	1
2	Food Purchase	(381)	0	0	0	0	0	0	0	0	0	0	(381)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	374	0	0	0	0	0	0	0	0	374	5
6	Maintenance	1,289	0	7,275	0	0	0	0	0	0	0	0	8,564	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	908	(6,000)	13,205	0	0	0	0	0	0	0	0	8,113	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	16,628	0	0	0	0	0	0	0	0	16,628	10
10a	Therapy	0	(1,333)	0	0	0	0	0	0	0	0	0	(1,333)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(1,333)	16,628	0	0	0	0	0	0	0	0	15,295	16
	C. General Administration													
17	Administrative	0	(219,600)	34,151	0	0	0	0	0	0	0	0	(185,449)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(168,000)	3,625	0	0	0	0	0	0	0	0	(164,375)	19
20	Fees, Subscriptions & Promotions	(11,040)	0	2,954	0	0	0	0	0	0	0	0	(8,086)	20
21	Clerical & General Office Expenses	(11,420)	(63,600)	50,929	0	0	0	0	0	0	0	0	(24,091)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	323	0	0	0	0	0	0	0	0	323	23
24	Travel and Seminar	0	0	341	0	0	0	0	0	0	0	0	341	24
25	Other Admin. Staff Transportation	0	0	1,555	0	0	0	0	0	0	0	0	1,555	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,018	0	0	0	0	0	0	0	0	3,018	26
27	Other (specify):*	0	0	25,681	0	0	0	0	0	0	0	0	25,681	27
28	**TOTAL General Administration**	(22,460)	(451,200)	122,577	0	0	0	0	0	0	0	0	(351,083)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,552)	(458,533)	152,410	0	0	0	0	0	0	0	0	(327,675)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **PARK HOUSE** **#** **0034991** **Report Period Beginning:** **01/01/2001** **Ending:** **12/31/2001**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(8,891)	43,465	6,939	0	0	0	0	0	0	0	0	41,513	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	275,792	11,569	0	0	0	0	0	0	0	0	287,361	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(365,009)	4,384	0	0	0	0	0	0	0	0	(360,625)	34
35	Rent-Equipment & Vehicles	0	(10,110)	4,665	0	0	0	0	0	0	0	0	(5,445)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,891)	(55,862)	27,557	0	0	0	0	0	0	0	0	(37,196)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,443)	(514,395)	179,967	0	0	0	0	0	0	0	0	(364,871)	45

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY
				2320 S LAWNDALE L	NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY CONSLT	$ 6,000	CAREPLUS MGMT INC		$	$ (6,000)	1
2	V	17	MANAGEMENT FEES	219,600	" "			(219,600)	2
3	V	19	ADMIN. CONSULTANT FEES	156,000	" "			(156,000)	3
4	V	19	DATA PROCESSING FEES	12,000	" "			(12,000)	4
5	V	21	CLERICAL FEES	63,600	" "			(63,600)	5
6	V	35	COMPUTER LEASE	10,110	" "			(10,110)	6
7	V								7
8	V	10a	THERAPY SERVICES	10,800	CAREPLUS REHABILITATIVE SERVICES		9,467	(1,333)	8
9	V								9
10	V	34	RENT	365,009	2320 S LAWNDALE LLC			(365,009)	10
11	V	30	SL DEPRECIATION		" "		43,465	43,465	11
12	V	32	INTEREST		" "		275,792	275,792	12
13	V								13
14	Total			$ 843,119			$ 328,724	$ * (514,395)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$	CAREPLUS MGMT INC	100.00%	$ 5,556	$ 5,556	15
16	V	5	ELECTRICITY		" "		374	374	16
17	V	6	REPAIRS		" "		213	213	17
18	V	6	MAINTENANCE SALARIES		" "		7,062	7,062	18
19	V	10	NURSING SALARIES		" "		16,628	16,628	19
20	V	10a	THERAPY SUPPLIES/SERVICES		" "				20
21	V	10a	THERAPY SALARIES		" "				21
22	V	17	ADMIN SALARIES		" "		34,151	34,151	22
23	V	19	PROFESSIONAL FEES		" "		3,625	3,625	23
24	V	20	DUES/LICENSES/WANT ADS		" "		2,954	2,954	24
25	V	21	OFFICE EXPENSES		" "		13,479	13,479	25
26	V	21	CLERICAL SALARIES		" "		37,450	37,450	26
27	V	23	SEMINARS		" "		323	323	27
28	V	24	TRAVEL		" "		341	341	28
29	V	25	TRANSPORTATION		" "		1,555	1,555	29
30	V	26	INSURANCE		" "		3,018	3,018	30
31	V	27	EMPLOYEE BENEFITS		" "		25,681	25,681	31
32	V	30	SL DEPRECIATION		" "		6,939	6,939	32
33	V	32	INTEREST		" "		11,569	11,569	33
34	V	34	OFFICE RENT		" "		4,384	4,384	34
35	V	35	EQUIP RENT/AUTO LEASE		" "		4,665	4,665	35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 179,967	$ * 179,967	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	JAKOB BAKST	DIR OPERATIONS	ADMIN, CONSULT		SEE ATTACHED			SALARY	10,232	17-7	2
3	SHERWIN I. RAY	PRESIDENT	ADMIN, FINANCE,		SCHEDULES			" "	10,232	17-7	3
4			BANKING								4
5											5
6											6
7											7
8	ERIC ROTHNER (HUNTER LLC)		ADMIN,CONSULT		" "			MGMT FEE	42,000	17-3	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 62,464		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MGMT
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	606,625	15	$ 83,890	$ 89,890	33,550	$ 5,556	1
2	5	ELECTRICITY	" "	606,625	15	6,767		33,550	374	2
3	6	REPAIRS	" "	606,625	15	3,858		33,550	213	3
4	6	MAINTENANCE SALARIES	" "	606,625	15	127,691	127,691	33,550	7,062	4
5	10	NURSING SALARIES	" "	606,625	15	300,646	300,646	33,550	16,628	5
6	10a	THERAPY SUPPLIES/SERVICES	" "	606,625	15	15,283			0	6
7	10a	THERAPY SALARIES	" "	606,625	15	96,375	96,375		0	7
8	17	ADMIN SALARIES	" "	606,625	15	617,499	617,499	33,550	34,151	8
9	19	PROFESSIONAL FEES	" "	606,625	15	65,550		33,550	3,625	9
10	20	DUES/LICENSES/WANT ADS	" "	606,625	15	53,408		33,550	2,954	10
11	21	OFFICE EXPENSES	" "	606,625	15	243,714		33,550	13,479	11
12	21	CLERICAL SALARIES	" "	606,625	15	677,141	677,141	33,550	37,450	12
13	23	SEMINARS	" "	606,625	15	5,849		33,550	323	13
14	24	TRAVEL	" "	606,625	15	6,170		33,550	341	14
15	25	TRANSPORTATION	" "	606,625	15	28,114		33,550	1,555	15
16	26	INSURANCE	" "	606,625	15	54,564		33,550	3,018	16
17	27	EMPLOYEE BENEFITS	" "	606,625	15	464,335		33,550	25,681	17
18	30	SL DEPRECIATION	" "	606,625	15	125,471		33,550	6,939	18
19	32	INTEREST	" "	606,625	15	209,175		33,550	11,569	19
20	34	OFFICE RENT	" "	606,625	15	79,265		33,550	4,384	20
21	35	EQUIP RENT/AUTO LEASE	" "	606,625	15	84,343		33,550	4,665	21
22										22
23										23
24										24
25	TOTALS					$ 3,349,108	$ 1,909,242		$ 179,967	25

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: 2320 S LAWNDALE LLC						$	$			$	1
2	NOMURA		X	MORTGAGE	$2,468.00	12/95	3,185,096	2,910,781			261,226	2
3												3
4	CAREPLUS MANAGEMENT	X		CAPITAL IMPRV LOAN				192,172			14,566	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$2,468.00		$ 3,185,096	$ 3,102,953			$ 275,792	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 3,185,096	$ 3,102,953			$ 275,792	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	63,790	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	71,075	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,285	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	72,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	79,785	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	47,158	8
	1997	62,474	9
	1998	63,583	10
	1999	63,156	11
	2000	71,075	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARK HOUSE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0034991

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-26-105-075-0000	NURSING HOME	$ 30,730.05	$ 30,730.05
2.	16-26-105-080-0000	NURSING HOME	$ 20,210.56	$ 20,210.56
3.	16-26-105-079-0000	NURSING HOME	$ 20,134.86	$ 20,134.86
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 71,075.47	$ 71,075.47

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,849 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,000	1995	$ 100,000	1
2					2
3	TOTALS	51,000		$ 100,000	3

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5	106		1989		1,209,350	38,397	39	38,397		497,552	5
6											6
7											7
8						6,939		6,939			8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1989	17,739	563	20	887	324	10,885	9
10	LEASEHOLD IMPROVEMENTS			1989	4,204	280	15	280		3,570	10
11	LEASEHOLD IMPROVEMENTS			1990	11,700	371	20	585	214	6,624	11
12	LEASEHOLD IMPROVEMENTS			1991	17,413	553	20	871	318	9,145	12
13	LEASEHOLD IMPROVEMENTS			1992	55,138	1,858	31.5	1,750	(108)	16,946	13
14	LEASEHOLD IMPROVEMENTS			1993	26,399	748	31.5	838	90	7,123	14
15	LEASEHOLD IMPROVEMENTS			1994	3,400	87	39	87		678	15
16	ROOF REPAIR			1995	1,500	38	39	38		249	16
17	ROOF-TOP HEAT/A/C			1996	10,000	256	39	256		1,505	17
18	CEILING TILE / DUMBWAITER REPAIR			1996	12,253	314	39	314		1,767	18
19	RE-ROOF			1996	80,861	2,073	39	2,073		11,054	19
20	FIXTURES / WINDOWS			1996	3,850	99	39	99		514	20
21	WINDOWS			1997	18,900	483	39	483		2,102	21
22	ROOF REPAIR & ROOF-TOP HEAT/A/C INSTALLATION			1997	3,228	82	39	82		372	22
23	DOOR & FLOORING			1997	2,922	75	39	75		341	23
24	ELEVATOR REPAIR			1997	3,125	80	39	80		350	24
25	WINDOWS			1998	12,600	323	39	323		1,212	25
26	TILE AND FLOORING			1998	23,810	611	39	611		2,276	26
27	ELECTRICAL, PLUMBING, AND ELEVATOR REPAIR			1998	31,238	801	39	801		2,912	27
28	NEW NURSES STATIONS			1998	24,271	622	39	622		2,411	28
29	WINDOW TREATMENTS AND BRAILLE SIGNS			1998	3,478	89	39	89		330	29
30	FIRE SYSTEM UPGRADE AND DAMPERS			1998	8,833	225	39	225		757	30
31	REAR PARKING LOT REPAIRS			1998	10,550	704	15	704		2,463	31
32	WINDOWS / CLOSETS / OUTLETS / DUMBWAITER / ROOF			1999	23,174	594	39	594		1,609	32
33	ROOF REPAIR			1999	18,365	471	39	471		1,197	33
34	FRONT RAMP REPAIR			2000	1,200	44	27.5	44		30	34
35	VINYL TILE / KITCHEN			2000	6,213	226	27.5	226		330	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DUMBWAITER REPAIR	2001	$ 3,264	$ 94	27.5	$ 94	$	$ 94	37
38	SIDEWALK / TUCKPOINTING	2001	5,500	183	15	183		183	38
39	KEYPAD ENTRY SYSTEM	2001	3,800	17	27.5	17		17	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,658,278	$ 58,300		$ 59,138	$ 838	$ 586,598	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 140,333	$ 18,232	$ 13,250	$ (4,982)	10	$ 67,677	71
72	Current Year Purchases	31,648	6,329	1,582	(4,747)	10	1,582	72
73	Fully Depreciated Assets	81,038			0		81,038	73
74	RELATED PARTY	200,000			0	10	200,000	74
75	TOTALS	$ 453,019	$ 24,561	$ 14,832	$ (9,729)		$ 350,297	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,211,297	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 82,861	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 73,970	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,891)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 936,895	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 20,856 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PARK HOUSE **#** 0034991 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	1,000,650		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,788		6
7	Other Prepaid Expenses	3,791		7
8	Accounts Receivable (owners or related parties)	645,000		8
9	Other(specify): RE TAX ESCROW	26,022		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,678,251	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	289,182		15
16	Equipment, at Historical Cost	253,019		16
17	Accumulated Depreciation (book methods)	(218,568)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Replacement Reserve	17,125		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 340,758	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,019,009	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 323,439	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,627		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,604		31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 474,170	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	60,687		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 60,687	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 534,857	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,484,152	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,019,009	$ 0	48

***(See instructions.)**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,505,748	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENTS	(117,364)	3
4	ILLINOIS REPLACEMENT TAX	(7,619)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,380,765	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	103,387	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 103,387	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,484,152	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,436,674	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,436,674	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	26,950	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 26,950	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,331	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,331	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,489,955	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	669,427	31
32	Health Care	1,157,662	32
33	General Administration	1,003,337	33
	B. Capital Expense		
34	Ownership	498,107	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,386,568	40
41	**Income before Income Taxes (line 30 minus line 40)****	103,387	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 103,387	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,069	2,181	$ 50,685	$ 23.24	1
2	Assistant Director of Nursing	2,041	2,148	46,139	21.48	2
3	Registered Nurses	3,897	4,188	86,153	20.57	3
4	Licensed Practical Nurses	12,278	13,181	216,136	16.40	4
5	Nurse Aides & Orderlies	48,326	51,857	439,271	8.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,221	7,132	74,357	10.43	8
9	Activity Director	2,119	2,293	26,914	11.74	9
10	Activity Assistants	3,804	4,202	33,826	8.05	10
11	Social Service Workers	5,764	6,601	90,082	13.65	11
12	Dietician					12
13	Food Service Supervisor	2,021	2,166	28,279	13.06	13
14	Head Cook	4,921	5,429	46,809	8.62	14
15	Cook Helpers/Assistants	8,471	9,074	61,388	6.77	15
16	Dishwashers					16
17	Maintenance Workers	1,760	1,796	17,561	9.78	17
18	Housekeepers	17,044	18,154	132,472	7.30	18
19	Laundry	3,096	3,494	28,820	8.25	19
20	Administrator	1,853	2,162	50,608	23.41	20
21	Assistant Administrator	1,926	2,523	54,750	21.70	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,206	2,398	17,599	7.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,817	140,979	$ 1,501,849 *	$ 10.65	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,000	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	2,064	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	375	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,376	11-3	44
45	Social Service Consultant	E	3,150	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,765		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EUGENE BERGER	ADMIN	0	$ 50,608
DENISE WILLIALMS	ASST ADMIN	0	54,750
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 105,358

B. Administrative - Other

Description	Amount
CAREPLUS MANAGEMENT	$ 219,600
HUNTER MANAGEMENT	42,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 261,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS	DATA PROCESSING	$ 12,000
AMERICAN DATA	DATA PROCESSING	1,575
ECONOCARE	DATA PROCESSING	1,417
ART ROUSEAU	LEGAL	125
FINKLE, MARTWICK	LEGAL	220
SACHNOFF & WEAVER	LEGAL	70
MEYER MAGENCE	LEGAL	1,392
KRUPNICK, BOKOR, KAGDA	ACCOUNTING	23,400
PERSONNEL PLANNER	UC CONSULTANT	995
CAREPLUS MNGT.	ADMIN CONSULTANT	156,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 197,194

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,958
Unemployment Compensation Insurance	14,007
FICA Taxes	113,525
Employee Health Insurance	66,881
Employee Meals	12,045
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,618
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	17,515
CHICAGO HEAD TAX	3,612
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 271,161

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,531
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	8,843
RELATED PARTY	2,954
CONTRIBUTIONS	2,197
DUES & SUBSCRIPTIONS	4,026
LICENSES & PERMITS	1,620
LESS CONTRIBUTIONS	(2,197)
Less: Public Relations Expense	(0)
Non-allowable advertising	(7,306)
Yellow page advertising	(1,537)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,131

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
RELATED PARTY	341
Seminar Expense	
EDUCATION AND SEMINAR	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 341

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 2,145	3	$ 358	$ 715	$ 715	$ 357	$	$	$	$	$
2	PAINT/DECORATING	2000	2,797	3			467	932	932	466			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,942		$ 358	$ 715	$ 1,182	$ 1,289	$ 932	$ 466	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $ 1,697.**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **490** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **58,035**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,045** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: PARK HOUSE **#0034991** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,000	
	REPAIRS & MAINTENANCE		1,241	
			0	7,241
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		37,798	
	ELECTRICITY		28,320	
	WATER		8,342	
	CABLE TV - LOBBY		691	
			0	75,151
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,601	
	PAINTING & DECORATING		695	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,646	
	ELEVATOR MAINTENANCE & REPAIR		10,259	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,600	
	FIRE SERVICE		3,202	
			0	
			0	
			0	24,003
7	**OTHER**			
	SCAVENGER		14,592	
	SECURITY SERVICE		0	14,592
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0	0

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	176	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,064	
	PHARMACY CONSULTANT	XVIII B 39-2	375	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	2,615
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTAI	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	10,800
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,376	
			0	2,376
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,150	
			0	3,150
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PARK HOUSE **#0034991** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		975	975
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	261,600	261,600
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,575	
	ADMINISTRATIVE CONSULTANTS	XIX C	156,000	
	PROFESSIONAL FEES	XIX C	27,619	
			0	197,194
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,306	
	EMPLOYEE WANT ADS	XIX F	6,531	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	4,026	
	LICENSES & PERMITS	XIX F	1,620	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,537	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,697	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	23,217
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		0	
	EQUIPMENT REPAIR & MAINTENANCE		8,221	
	OUTSIDE CLERICAL SERVICES		63,600	
	PENALTIES / OVERDRAFT CHARGES	VI 18	11,420	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,499	
	MESSENGER SERVICE		0	
			0	103,740

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	113,525	
	UNEMPLOYMENT COMPENSATION	XIX D	14,007	
	WORKERS COMPENSATION INSURANC	XIX D	40,958	
	HOSPITALIZATION INSURANCE	XIX D	66,881	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,618	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	17,515	
	CHICAGO HEAD TAX	XIX D	3,612	259,116
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		675	675
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		249	249
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		27,519	27,519
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,014,213

PARK HOUSE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	122,686
LESS SALES TAX	(381)
NET FOOD	123067
TOTAL PATIENT CENSUS	33,550
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	100650
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	10950

PATIENT MEALS	100650
ADD EMPLOYEE MEALS	10950
TOTAL MEALS/YEAR	111600
NET FOOD	123067
DIVIDE TOTAL MEALS/YEAR	111600
COST PER MEAL	1.1
TIME EMPLOYEE MEALS	10950
EMPLOYEE MEAL RECLASSIFICATION	12045